

# ACCREDITATION GUIDE FOR HOSPITALS



Dear Colleague,

Thank you for looking to The Joint Commission when it comes to your accreditation needs. Joint Commission recognition is a visible demonstration to your patients, their families, your staff and the community of your commitment to the highest level of safety and quality.

*The Accreditation Guide for Hospitals* is designed to help you learn about the Joint Commission's accreditation process. This guide provides information about several important areas including eligibility, how to request accreditation and prepare for the process, the on-site survey process, and accreditation decisions.

We hope that you will find this guide helpful in understanding the accreditation process. If you have questions, or would like to speak with someone directly, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Mark Pelletier". The signature is written in a cursive style with a large initial "M".

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## **Telephone and Website Directory**

**Hospital Program..... (630) 792-5291**

To receive an initial Application for Accreditation, or for general information about hospital accreditation.

**Your Joint Commission Account Executive ..... (630) 792-3007**

Call to inquire about your completed Application for Accreditation, survey date or schedule or for assistance with specific questions related to your accreditation.

**Joint Commission Resources (JCR) Customer Service Center ..... (877) 223-6866**

To register for, or receive information about education programs and to purchase or inquire about publications. JCR is an affiliate of The Joint Commission. Online registration and ordering is available at [www.jcrinc.com](http://www.jcrinc.com).

**Standards Interpretation Group**

For information about interpreting and applying specific hospital standards, or inquiries about the Statement of Conditions, Life Safety Code, or equipment and utilities management, please contact the Standards Interpretation Group. An online request can be completed and submitted at [https://www.jointcommission.org/standards\\_information/jcfaq.aspx](https://www.jointcommission.org/standards_information/jcfaq.aspx).

**Joint Commission Pricing Unit ..... (630) 792-5115**

For information on accreditation fees, or to handle your application deposit fee via credit card payment. Also available via e-mail at [pricingunit@jointcommission.org](mailto:pricingunit@jointcommission.org).

**Joint Commission Website..... [www.jointcommission.org](http://www.jointcommission.org)**

- Current Joint Commission news
- Information about revisions to standards
- Quality Check<sup>®</sup>, a searchable list of health care organizations within a city or state, or by type of setting, with information about accreditation status ([www.qualitycheck.org](http://www.qualitycheck.org))
- Helpful tips for publicizing accreditation status
- Listing of Liability Insurers that recognize Joint Commission accreditation
- Frequently asked questions (FAQs)

## **Hospital Resources**

### **Hospital Business Development Staff**

Business Development staff work closely with organizations preparing for their first accreditation. Any questions that you have about the overall accreditation process and your preparation efforts can be directed to (630) 792-5291.

## **Standards Interpretation**

The Joint Commission website contains frequently asked questions (FAQs) for many areas of potential concern for hospitals. Many of these questions are posted by the Standards Help Desk under “Standards” on the website, so you may find answers by checking the FAQs: [https://www.jointcommission.org/standards\\_information/jcfaq.aspx](https://www.jointcommission.org/standards_information/jcfaq.aspx)

## **Survey Activity Guide**

Once you request an Application for Accreditation, you will gain access through a secure log-in to the Joint Commission extranet site, “Joint Commission Connect®”. There you will find a Survey Activity Guide, which goes into greater detail about the on-site survey and provides further information about preparing for the experience.

# **The Joint Commission Snapshot**

## **Introduction**

The *Accreditation Guide for Hospitals* is designed to help you learn about the Joint Commission’s hospital accreditation process. This guide provides important information about The Joint Commission, eligibility for accreditation, the hospital accreditation standards, on-site surveys, survey preparation, and accreditation decisions.

## **Our Mission**

To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

## **The Joint Commission: Who Are We?**

The Joint Commission was founded in 1951 under the auspices of the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons, with the later addition of the American Dental Association, to act as an independent accrediting body for hospitals nationwide. As such, The Joint Commission currently accredits over 80% of U.S. hospitals.

## **Why Choose The Joint Commission?**

Today, Joint Commission accreditation of a hospital is a widely recognized standard for evaluating and demonstrating high quality services. Payers, regulatory agencies, and managed care contractors may require Joint Commission accreditation for reimbursement, certification and licensure, or as a key element of their participation agreements. Joint Commission accreditation represents the “Gold Seal of Approval™” in health care and provides the most comprehensive evaluation process in the industry. Joint Commission accreditation also benefits

your organization by:

- **Strengthening community confidence**  
Achieving accreditation is a visible demonstration to the community that your hospital is committed to providing high quality services, as reviewed by an external group of specialists.
- **Validating quality care to your patients and their families**  
Joint Commission standards are focused on one goal: raising the safety and quality of care to the highest possible level. Achieving accreditation is a strong validation that you have taken the extra steps to ensure the highest level of safety and quality currently available.
- **Helping you organize and strengthen your improvement efforts**  
Joint Commission standards include state-of-the-art performance improvement concepts that provide a framework for continuous improvement using standards as a means to achieve and maintain excellent operational systems.
- **Improving liability insurance coverage**  
By enhancing risk management efforts, accreditation may improve access to or reduce the cost of liability insurance coverage. A list of liability insurers that recognize Joint Commission accreditation can be found on our website at:  
[http://www.jointcommission.org/liability\\_insurers/default.aspx](http://www.jointcommission.org/liability_insurers/default.aspx)
- **Enhancing staff recruitment and education**  
The accreditation process is designed to be educational, not punitive. Our surveyors are trained to help you improve your internal procedures and day-to-day operations in a consultative manner. Prospective employees also look for accreditation as a sign of excellence in an organization.

## **What Types of Facilities are Eligible for Hospital Accreditation?**

Any health care organization may apply for Joint Commission accreditation under the Hospital Accreditation standards if all the following requirements are met:

- The organization is in the United States or its territories or, if outside the United States, is operated by the U.S. government, under a charter of the U.S. Congress.
- The organization assesses and improves the quality of its services. This process includes a review of care by clinicians, when appropriate.
- The organization identifies the services it provides, indicating which services it provides directly, under contract, or through some other arrangement.
- The organization provides services addressed by the Joint Commission's standards.
- If the organization uses its Joint Commission accreditation for deemed status purposes, the organization meets the Centers for Medicare & Medicaid Services definition of a "hospital."

A hospital that is seeking Medicare certification and is new to The Joint Commission must, at the time of survey, have:

- Two active inpatient cases.
- If your Average Daily Census (ADC) is 21 or more or your organization is a specialty hospital (cardiac, orthopedic, or surgical), you must be able to provide inpatient records for at least 10 percent of the ADC, but not less than 30 inpatient records.
- If your ADC is 1-20, you must be able to provide 20 inpatient records.
- If you are not sure about whether the 20 or 30 inpatient records is the appropriate sample size for your organization refer to your 855 Medicare application to determine how you reported yourself to Medicare and then contact your assigned Joint Commission Account Executive to determine the correct minimum requirements applicable to your organization.
- If you do not have a CCN, a letter from the Fiscal Intermediary on CMS Letterhead indicating that the Medicare application (855A) was reviewed and accepted.
- Licensure Survey results
- Copy of License
- Letter notifying CMS and the State Department of Health that The Joint Commission is conducting your deemed Status Survey.

A hospital that is not seeking Medicare certification and is new to The Joint Commission must, at the time of survey, have:

- One active inpatient case.
- 10 inpatient records.

## **Laboratory Accreditation Component**

Laboratory services offered by a hospital play an important role in providing patient care. As a result, The Joint Commission requires all non-waived CLIA certificates that are performing laboratory testing onsite to be accredited. This includes specialties provided through a contracted service (common examples are Anatomic Pathology and Blood Bank). Choosing Joint Commission accreditation for the laboratory builds upon the common foundations of process improvement, the environment of care, infection control and leadership that are already in place to meet the Joint Commission hospital requirements. A state inspection does not meet the requirement of accreditation and may result in a Joint Commission initial survey for the laboratory. Joint Commission Cooperative partners may also be used to meet the laboratory accreditation requirement.

## **Standards, Goals and Survey Process**

### **The Standards Manual**

Joint Commission standards address critical patient safety and overall quality issues, and



presented as patient-focused or organization-focused functions and processes. The Joint Commission's *Comprehensive Accreditation Manual for Hospitals (CAMH)* is the place to begin when preparing for accreditation. Even if you do not pursue accreditation right away, this manual is an excellent tool to help your hospital organize with a focus on a commitment to providing safe, quality patient care, treatment and services. The *CAMH* contains functional standards that are organized around the way care is provided. It is provided free of charge upon receipt of your accreditation deposit or can be provided earlier. Call (630) 792-5291 for more information.

## **Patient-Focused Functions**

The patient-focused section of the *CAMH* includes chapters on Infection Control, Medication Management, Provision of Care, and Rights and Responsibilities.

### Infection Prevention and Control

These standards are designed to help hospitals in developing and maintaining practices that cover a wide range of situations.

### Medication Management

These standards address a well-planned and implemented medication management system, including selection and procurement, storage, ordering, preparation and dispensing, administration and monitoring.

### Provision of Care, Treatment, and Services

This chapter addresses assessment of patient needs, care planning, and providing and coordinating care.

### Rights and Responsibilities of the Individual

Standards address the following processes:

- Informing patients of their rights
- Helping patients understand and exercise their rights
- Respecting patients' values, beliefs, and preferences
- Informing patients of their responsibilities regarding their care, treatment and services

## **Organization Functions**

This section of the *CAMH* includes chapters on Environment of Care, Emergency Management, Human Resources, Information Management, Leadership, Life Safety, Medical Staff, Nursing, Performance Improvement, and Record of Care.

### Management of the Environment of Care

These standards promote a safe, functional and supportive environment within the hospital so that quality and safety are preserved. The environment of care is made up of the building or space, including how it is arranged and special features that protect patients, visitors and staff. It also encompasses the equipment used to support patients and the people, including employees, patients and visitors.

### Emergency Management

These standards are organized to allow hospitals to plan to respond to the effects of potential

emergencies that range from disruptive to disastrous.

#### Human Resources

The standards and elements of performance address the hospital's responsibility to establish and verify staff qualifications, orient staff, and provide training that staff needs to support the care, treatment and services that the hospital provides.

#### Management of Information

These standards address how well the hospital obtains, manages and uses information to provide, coordinate and integrate services.

#### Leadership

These standards are divided into four different areas to address all organizational areas so that they come together to shape and drive the hospital's operations:

- Leadership Structure
- Leadership Relationships
- Hospital Culture and System Performance
- Operations

#### Life Safety

This chapter includes all the Joint Commission requirements regarding *Life Safety Code* compliance, which specifies construction and operational conditions to minimize fire hazards and provide safe systems in case of emergency.

#### Medical Staff

These standards provide structure for self-governing medical staff, licensed independent practitioners and other medical staff personnel.

#### Nursing

This chapter addresses nursing direction, establishing guidelines for delivery of care and providing treatment, nursing care and services.

#### Performance Improvement

These standards focus the hospital on measuring the performance of processes that support care and then using data to make improvements.

#### Record of Care, Treatment, and Services

Comprehensive sets of requirements for medical record contents are provided and standards address policies and procedures that structure the compilations, authentication, retention and release of records.

### **The Joint Commission Patient-Centered Accreditation Process**

The purpose of a Joint Commission accreditation survey is to assess the extent of an organization's compliance with applicable Joint Commission standards, National Patient Safety Goals, and Accreditation Participation Requirements. Another important aspect of the Joint Commission survey process is the on-site education as surveyors offer suggestions for

approaches and strategies that may help the organization better meet the intent of the standards and, more importantly, improve performance. While integrating evaluation of standards compliance and educating an organization, the Joint Commission accreditation process also emphasizes quality patient care.

Although surveys for hospitals are triennial (conducted every three years) the accreditation process does not end when the on-site survey is completed. In the three years between on-site surveys, The Joint Commission requires ongoing self-assessment and improvement.

Continuous survey compliance means less focus on the 'ramp up' for survey every three years. Instead, organizations can and should continually study and improve their systems and operations, eliminating the need for intense survey preparation. Continuous compliance with the Joint Commission standards directly contributes to the maintenance of safe, high quality patient care and improved organizational performance.

### **Tracer Methodology**

Tracer Methodology utilizes the patient care experience to assess standards compliance. At the beginning of the on-site survey, the surveyor(s) will select a sample of patients from the hospital's current inpatient census and outpatient registrations, as well as identify a number of recently discharged patients to follow on the survey. The surveyor(s) will 'trace' the patient's experience, looking at the services provided by various departments and staff throughout the organization, as well as 'hand-offs' between them. This type of review is designed to uncover systems issues, looking at both the individual components of an organization and how the components interact to provide safe, high-quality patient care.

There are two types of tracers used in the Tracer Methodology:

- The **Individual Patient Tracer** follows the actual care experiences of individuals who are currently receiving or have recently received care, treatment and services within or from that organization.
- The **Individual-based System Tracer** traces the experience of individuals through a specific system related to the provision of care, treatment and services. The system tracer focuses on high-risk processes across an organization.

The number of patients followed under the Tracer Methodology will depend on the size and complexity of the organization.

### **Evidence of Standards Compliance**

At the end of the on-site survey, the report left with the organization will identify if there are any standards that were non-compliant, also known as **Requirements for Improvement (RFIs)**.

RFIs are identified by evaluating an organization's compliance with the **Elements of Performance (EPs)** associated with each standard, and National Patient Safety Goal. EPs are the portion of the standard that are scored by the surveyor on site. Standards and associated EPs that are non-compliant will be cited as RFIs and will be assessed for risk by utilizing the Survey Analysis for Evaluating Risk™ (SAFER™) matrix. Each RFI is placed on the SAFER matrix according to how likely it is that the RFI will harm a patient(s), staff, and/or visitor (low, moderate, high) and the scope, or prevalence, at which the RFI was cited (limited, pattern, widespread). The final SAFER matrix is included within the survey report.

If there are no RFIs, the organization is accredited. If there are RFIs, the organization will not receive accreditation status until they are resolved. For those standards scored as non-compliant, the organization will need to submit **Evidence of Standards Compliance (ESC)** to show that the organization is now meeting those standards and EPs.

ESCs must be submitted within 60 days following the survey. Once the ESCs are approved by The Joint Commission, the organization is officially accredited. See page 19 for a description of the accreditation status decisions.

## **Performance Measurement Requirements**

The **Joint Commission's ORYX®** initiative integrates performance measurement data into the accreditation process. **ORYX** measurement requirements are intended to support **Joint Commission**-accredited organizations in their quality improvement efforts. Since 2002, hospitals have been reporting data to The Joint Commission as a requirement of accreditation. There has been significant change in the ORYX requirements, most notably in 2015. 2015 was a year of significant transition in performance measurement for The Joint Commission. The Joint Commission retired 20 measures that had consistently excellent performance, introduced flexible reporting options to allow organizations choice in which measures to report, and accepted electronic clinical quality measure (eCQM) data for the first time. Despite the challenges of our rapidly changing environment, hospitals continued to improve their quality performance results. Through eCQMs, hospitals can electronically collect and transmit data on the care that patients receive – data that can be analyzed to measure and improve care processes, performance, and outcomes.

On an annual basis, hospitals select measures from the list of available Joint Commission measures for submission to The Joint Commission. Details regarding the ORYX requirements, including measures and measure specifications, can be found on the “performance measurement” tab of the Joint Commission website:

([https://www.jointcommission.org/performance\\_measurement.aspx](https://www.jointcommission.org/performance_measurement.aspx)).

For more information please contact our ORYX team, at [oryx@jointcommission.org](mailto:oryx@jointcommission.org) or (630) 792-5085.

## **Random Unannounced ESC Validation Survey**

All organizations new to the accreditation process that become accredited after their initial survey will be included in a 5% pool of organizations undergoing an unannounced validation survey. This survey will validate information in the organizations' Evidence of Standards Compliance and evaluate how effectively corrective actions are sustained over time. There is no charge to organizations for this survey.

## **National Patient Safety Goals**

National Patient Safety Goals (NPSGs) address important patient safety issues. Safety issues are considered for an NPSG if:

- There is evidence that the issue has resulted in serious patient harm

- The issue is widespread and affects many people
- The issue is preventable
- There is benefit in bringing the issue to the attention of the field through the spotlight of an NPSG.

The NPSGs include evidence-based solutions for the safety issue to the extent that solutions exist. If no universally agreed-upon solutions exist, the NPSG will address processes that can be used to manage the risk.

A panel of national safety experts advises the Joint Commission about safety issues that can be considered for National Patient Safety Goals. Organizations are evaluated for compliance with the National Patient Safety Goals that are relevant to the care they provide.

An example of the National Patient Safety Goals content and structure (requirement and implementation expectations) is illustrated with Goal 1 – Improve the accuracy of patient identification

#### **NPSG.01.01.01**

Use at least two patient identifiers when providing care, treatment or services.

##### *Rationale for -- NPSG.01.01.01*

Wrong-patient errors occur in virtually all aspects of diagnosis and treatment. The intent for this goal is two-fold; first, to reliably identify the individual as the person for whom the service or treatment is intended; second to match the service or treatment to that individual. Acceptable identifiers may be the individual's name, and assigned identification number, telephone number, or other person-specific identifier.

#### **NPSG.01.01.01, EP 1**

Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11; NPSG.01.03.01, EP 1)

#### **NPSG.01.01.01, EP 2**

Label containers used for blood and other specimens in the presence of the patient. (See also NPSG.01.03.01, EP 1)

The National Patient Safety Goals and frequently asked questions (FAQs) about the National Patient Safety Goals can be found on the Joint Commission website by clicking on hospitals or critical access hospitals at:

<http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals>.

The FAQs include detailed answers about implementing the Goals.

## **Our Standards Represent a National Consensus**

The Joint Commission's hospital standards and accreditation processes are the result of careful analysis of the rapidly changing health care field. Every effort is made to provide reasonable guidelines that every hospital should strive to meet.

## **Our Surveyors: Hospital Professionals**

Joint Commission hospital surveyors are salaried professionals experienced in the hospital arena, who understand the day-to-day issues that confront you and have the hands-on expertise to help you resolve them. A Joint Commission hospital on-site survey can be conducted by a physician, masters-prepared nurse and/or administrator, the majority of who are also currently practicing in the hospital field.

The Joint Commission ensures surveyor consistency by providing 2-3 weeks of initial training and a minimum of 10 days of continuing education annually to keep surveyors up-to-date on advances in quality-related performance evaluation. All surveyors must also pass a rigorous Certification Exam. The Joint Commission evaluates its surveyors' performance continually throughout the year, in part to ensure that your on-site survey is an educational process, not just an inspection.

## **Preparing and Applying for Accreditation**

### **Accreditation Preparation**

The accreditation process begins when you submit your application. It is best to submit your application when you are confident your organization can demonstrate compliance with the accreditation requirements and applicable elements of performance by the time of your on-site survey date. See "How to Request Hospital Accreditation" section that follows.

After The Joint Commission accepts an organization's Application for Accreditation and receives the application deposit fee, both parties begin preparing for the on-site survey. An organization should begin by reviewing the accreditation requirements and conducting a self-assessment to see where improvements are needed, and then taking measures to put new policies or processes in place as needed. Many organizations find it helpful to conduct one or two "mock surveys" by using the self-assessment grid next to each element of performance in the Standards Manual. Use the [Ready to Go List](#) and the [Accreditation Readiness Checklist](#) that are provided in this the references section of this guide for further assistance.

To help organizations prepare for accreditation, The Joint Commission also offers the **Survey Activity Guide** on your "Joint Commission Connect<sup>®</sup>" extranet site where the application is located. In addition, Joint Commission Resources, an affiliate company, offers educational programs, numerous publications and periodicals to aid in your preparation.

The Joint Commission organizes a surveyor, or team of surveyors, to match an organization's needs and unique characteristics. The length of the survey depends on the complexity and

size of the organization. The on-site survey follows a Tracer Methodology, which follows a sample of patients through their experiences of care in the organization, to evaluate individual components of care and systems of care. The survey includes interviews with key personnel, observation of the organization's administrative and clinical activity, assessment of the physical facilities and equipment, and review of documentation. The Hospital Accreditation Survey Activity List and the Ready to Go List are additional tools that are included in the References section of this guide.

For initial accreditation surveys, your account executive is available as a resource during the application and pre-survey process.

## **Informing the Public Regarding Your On-Site Survey**

The Joint Commission requires all organizations seeking accreditation to continuously inform the public about their ability to report any complaints or concerns about safety or quality of care to The Joint Commission. The public includes, but is not limited to, patients and their families, patient advocates and advocacy groups, members of the community for who services are provided, and staff members. Any individual who learns that a Joint Commission survey is taking place may request a Public Information Interview during an on-site survey; however, there is no longer a formal process to notify the public in advance of the survey.

The Joint Commission will continue to conduct all special types of surveys – for-cause, special, random unannounced – as warranted. When The Joint Commission learns of a serious event at an organization that has significantly impacted the delivery of safe and high quality care, it will continue to authorize a for-cause unannounced survey.

## **Scheduling Initial Surveys**

The date for the initial survey, that is, an organization's first full accreditation on-site survey, will be unannounced, and is typically scheduled within twelve months from the time The Joint Commission receives the organization's Application for Accreditation. To encourage continuous standards compliance, future reaccreditation surveys are also unannounced.

## **Timeliness of Application and Deposit Fee**

The Joint Commission requires an organization to submit a new application for Accreditation if the organization does not accept a scheduled survey within one year. This assures that the organization's information is current. If an organization's initial survey is not conducted within one year of submitting its application, the organization forfeits its application deposit. The organization must then reapply and submit a new deposit to begin the accreditation process again.

## **How to Request Hospital Accreditation**

Hospitals that wish to be accredited by The Joint Commission can receive an application for Accreditation by either:

- calling **(630) 792-5291**

- e-mailing [hospital@jointcommission.org](mailto:hospital@jointcommission.org),
- or writing to:  
**Hospital Accreditation Program**  
**The Joint Commission**  
**One Renaissance Blvd**  
**Oakbrook Terrace, IL 60181**

## **The Application for Accreditation**

The Application for Accreditation is in an electronic format that can be completed by using a provided password and login name to access the Joint Commission Connect™ website, located at [www.jointcommission.org](http://www.jointcommission.org). The Application is valid for one year from the date submitted, which means you can submit your application and still have time to finish your preparations for the on-site survey.

It is best to submit your application at the point when you are confident your organization will be able to demonstrate compliance with the accreditation requirements by the time of your preferred survey date.

Your organization will be given password-protected access to the secure Joint Commission extranet site “Joint Commission Connect®” where you will find a Survey Activity Guide, a sample survey agenda, as well as a guide to the limited number of documents you will need to gather for the surveyor. You will also be assigned an account executive who will:

- Answer your questions about survey preparation, and help you through each step of the accreditation process;
- Analyze your Application for Accreditation and contact you if there are any questions or items requiring clarification;
- Assist with changes to your demographic information, including address, contact name(s), services, etc.;
- Assist you with other Joint Commission contacts and questions.

The Joint Commission schedules on-site surveys based on information provided in your Application for Accreditation. With the information provided, The Joint Commission determines the number of days required for a survey, the composition of the survey team and the services to be reviewed.

## **Handling Changes During the Application Process**

Organizations must notify The Joint Commission promptly, in writing, when an additional service is contemplated\* so any potential impact to accreditation can be determined. Medicare-certified organizations must also notify the Medicare Administrator Contractor promptly, in writing, when an additional service is contemplated. Once the change has actually occurred, the organization must update its E-App within 30 calendar days. Information that must be reported includes any of the following:

- A change in ownership



- A change in location
- A significant increase or decrease in the volume of services or individuals served
- The addition of a new type of health service, program, or site of care
- The deletion of an existing health service, program, or site of care
- The acquisition of a new component
- The deletion of an existing component

The Joint Commission may conduct an additional survey at a later date if its surveyor or survey team arrives at the [organization] and discovers that a change was not reported. The Joint Commission may also survey any unreported services and sites addressed by its standards during the survey as appropriate. The Joint Commission makes the final accreditation decision for the [organization] only after surveying all or an appropriate sample of all services, programs, and sites provided by the [organization] for which The Joint Commission has standards. Information reported in the E-App is subject to The Joint Commission's Information Accuracy and Truthfulness Policy.

## **Application Fee**

For initial surveys, a nonrefundable, nontransferable survey deposit of \$1,700 must be submitted at the time of the application. The Joint Commission applies the deposit to the organization's open invoices until the deposit is exhausted. To pay the survey deposit by credit card, call (630) 792-5115. Checks should be made payable to The Joint Commission and mailed to The Joint Commission, PO Box 92775, Chicago, IL 60675-2775. Please include your Joint Commission ID number on your check.

## **Fees and Annual Billing**

The Joint Commission currently uses an annual billing model, also called **subscription billing**. This billing model spreads the costs of accreditation over a three year period. The accreditation fee is based on an on-site survey fee due after the on-site survey, plus an annual fee every year of the accreditation cycle. Annual fees will vary depending upon the size and complexity of an organization, as determined by the information submitted in the electronic application.

Approximately 60% of the accreditation fees will be paid in the first year, with 20% due in each the second and third years.

The annual fees, which are non-refundable, will be due from accredited organizations each January upon receipt of an invoice. Organizations seeking accreditation for the first time will have their first annual fee pro-rated, based upon when the organization's application is processed.

The Joint Commission is committed to "cost transparency" to help organizations plan and budget for their future investment in achieving accreditation. Call our pricing unit directly for a customized quote at (630) 792-5115 or via email at [pricingunit@jointcommission.org](mailto:pricingunit@jointcommission.org).

## **Cost of Hospital Accreditation**

The cost for hospital accreditation depends on the complexity and size of the organization. For more information about pricing, contact the Joint Commission's pricing unit at 630-792-5115 or via email at [pricingunit@jointcommission.org](mailto:pricingunit@jointcommission.org).

## **Accreditation Options Hospital Accreditation**

The Joint Commission's premier accreditation product has earned industry recognition as the "gold standard" for quality and safety.

### **Early Survey Option for Hospital Accreditation**

Some organizations requesting a traditional hospital survey may not be quite ready for full evaluation. These organizations may prefer the Early Survey Option. The Early Survey Option allows a hospital new to Joint Commission accreditation to enter the accreditation process in two stages. For a new organization, this makes it possible to set up the business operations on a foundation of compliance with administrative and organizational standards before the first patients are served. The Early Survey Option is different than a normal, full survey in that it consists of two on-site visits.

#### **First Survey**

The first survey can be conducted announced as early as two months before the organization begins operations, provided the organization meets the following criteria:

- it is licensed or has a provisional license;
- the building in which patient care services will be provided is identified, constructed, and equipped to support such services;
- it has identified its chief executive officer or administrator, its director of clinical or medical affairs, and its nurse executive, if applicable;
- it has identified the date it will begin operations.

The Joint Commission requires written evidence of these criteria within 30 days before conducting the first survey. The first survey is a limited survey, addressing physical plant, policies and procedures, plans, and related structural considerations for patient care. Following this initial survey, assuming that the organization can demonstrate compliance with the abbreviated set of standards, the organization receives Limited Temporary Accreditation.

#### **Second Survey**

The second survey under the Early Survey Policy is an unannounced full accreditation survey. The Joint Commission conducts this survey at the following times:

- Approximately six months after the first survey

***or***

- At a time frame selected by the organization within four months of the acceptance of

its first Evidence of Standards Compliance (ESC) for organizations seeking to meet CMS deemed status requirements

Based on survey results, the organization's accreditation decision then changes to one of the following:

- Accredited
- Accreditation with Follow-up Survey
- Denial of Accreditation

The effective date of the accreditation decision is the day after the second survey if the organization does not receive any Requirements for Improvement (RFIs). If the organization receives at least one RFI and therefore must submit an acceptable ESC report that resolves all RFIs, the effective date for Accreditation is the date of the acceptable ESC submission. The organization's accreditation cycle begins the day after the second survey was conducted, unless The Joint Commission reached a decision to deny accreditation. Submission of an acceptable ESC may be required based on the survey findings of the second survey.

## **Accreditation Decisions**

### **Survey Results and Accreditation Decision**

Shortly after the survey, an organization's report of survey findings is posted on the organization's secure Joint Commission extranet site. The report includes any requested Requirements for Improvement (RFI).

The final accreditation decision, which is valid for three years, is based on the organization's compliance with Joint Commission standards and will be awarded a decision in one of these categories of accreditation:

### **Limited Temporary Accreditation**

The organization demonstrates compliance with selected standards on the first survey conducted under the Early Survey Policy.

### **Accredited**

The organization is in compliance with all standards at the time of the on-site survey or has successfully addressed all Requirements for Improvement (RFIs) in an Evidence of Standards Compliance (ESC) within 45 or 60 days following the posting of the Accreditation Survey Findings Report and does not meet any other rules for other accreditation decisions.

## **Accreditation with Follow-up Survey**

The organization is not in compliance with specific standards that require a follow-up survey within 30 days to 6 months. The health care organization also must successfully address the identified problem area(s) in an ESC submission.

## **Preliminary Denial of Accreditation**

There is justification to deny accreditation to the organization as evidenced by the following:

- An Immediate Threat to Health or Safety for patients or the public, and/or
- Failure to resolve the requirements of Accreditation with Follow-up Survey after two opportunities (in most cases), and/or
- Failure to resolve the requirements of Contingent Accreditation, and/or
- Significant noncompliance with Joint Commission standards

The decision is subject to review and appeal prior to the determination to deny accreditation.

## **Denial of Accreditation**

The organization has been denied accreditation. All review and appeal opportunities have been exhausted.

## **Accreditation Effective Dates**

For organizations that undergo their first Joint Commission survey (initial organizations) and receive one or more **Requirements for Improvement (RFIs)** as a result of the survey, their accreditation effective date will be on the date on which the organization submits its evidence of standards compliance (ESC), if the ESC is determined to be acceptable. In other cases, the following effective dates apply:

- For initial organizations that do not receive any RFIs, the effective date of accreditation will be the day after the last day of the organization's survey.
- For initial organizations that receive either a contingent accreditation or a preliminary denial of accreditation decision, the effective date will be the date of the Accreditation Committee meeting at which the decision was made.

## **Extension Survey**

Accreditation is not automatically transferred or continued if significant changes occur within an organization. An extension survey is a survey of limited scope conducted to assure that a previously demonstrated level of compliance is being maintained under changed circumstances. There are many circumstances that may lead to an extension survey, including:

- An organization's addition or significant expansion of services or programs;
- A change in organizational structure or operations due to a merger or acquisition;

- The addition of a more intensive level of patient care;
- A new location or significantly altered existing location; or
- When an accredited organization due for resurvey requests to extend the accreditation date.

See **Handling Changes** section of this guide for further information.

## **Intracycle Monitoring / Focused Standards Assessment**

Every accredited organization has access to an Intracycle Monitoring (ICM) Profile on their secure Joint Commission Connect extranet site. The Profile provides access to overview information regarding the organization's current accreditation status, major risk areas related to the accredited program, and numerous helpful tools, solutions, and resources available to the organization's continuous standards compliance activities.

The Focused Standards Assessment (FSA) tool is one component of the Profile. This standards self-assessment tool provides organizations with an ongoing opportunity to monitor their level of compliance with the standards and elements of performance in effect at the time of a self-assessment. The scoring methodology for the FSA is the same as that used by surveyors during an on-site survey.

### **Benefits of the FSA and options**

The ICM Profile and FSA review are intended to provide organizations with educational support during the intracycle period. Information exchanged during these reviews does not impact an organization's accreditation decision. The opportunity for a conference call with expert Joint Commission standards staff helps the organization stay on track and up to date with accreditation compliance.

Accredited organizations are required to submit an acknowledgement of this activity by the 12<sup>th</sup> and 24<sup>th</sup> months of their triennial accreditation cycle. Submission is not required at the 36<sup>th</sup> month of the triennial cycle. Organizations acknowledge their compliance with this requirement through one of four ICM Profile submission options:

### **Full FSA**

- The organization uses the FSA tool to assess and score compliance with elements of performance (EP) for applicable standards. At least the minimum subset of R-icon standards must be scored in order to accomplish a Full submission. Data entered into the FSA tool is copied to a historical submission record for future reference by the organization.
- For each EP scored not compliant, the organization creates a Plan of Action (POA) to restore the standard to full compliance.

- A conference call can be requested by either the organization or the Standards Interpretation Group (SIG) to discuss submitted POAs or other standards-related issues.
- If a conference call was not requested, Joint Commission staff may request the call in order to clarify information submitted in the Full FSA.

#### **Option 1 (Attestation)**

- The organization submits an attestation to affirm it has completed a standards self-assessment process, including the development of appropriate POAs.
- While organizations are encouraged to use the FSA tool to facilitate standards self-assessment activities, any data entered into the FSA tool is not copied to a historical submission record.
- The organization can submit standards-related topics in the ICM Profile for telephone discussion with SIG, if desired.

#### **Option 2 (On-site ICM survey, written documentation of findings)**

- The organization submits a request for an on-site educational survey that includes documented findings (additional fees apply).
- A surveyor assists the organization in the review of organization-identified high-risk areas. Standards compliance issues are documented in the FSA tool for the organization's follow-up action.
- Within 30 calendar days after the on-site event, the organization submits POA information for standards identified by the surveyor as not compliant.
- A conference call can be requested by either the organization or the Standard Interpretation Group (SIG) to discuss submitted POAs or other standards-related issues.

#### **Option 3 (On-site ICM survey, oral exit briefing)**

- The organization submits a request for an on-site educational survey that does not include documented findings (additional fees apply).
- A surveyor assists the organization in the review of organization-identified high-risk areas, but does not enter data in the FSA tool.
- Standards compliance information is provided to the organization through an oral exit briefing; there is no documented record of any event findings.

For more information about Intracycle Monitoring and the FSA tool, visit The Joint Commission website at [www.jointcommission.org](http://www.jointcommission.org). Accredited organizations may also visit their secure site on The Joint Commission Connect extranet, review their accreditation manual, or contact their account executive.

## **Promoting Your Accreditation**

Once you are accredited by The Joint Commission, publicize your achievement by notifying the public, the local media, third-party payers and patient referral sources. The Joint Commission offers a free publicity kit at:

[http://www.jointcommission.org/accreditation/accreditation\\_publicity\\_kit.aspx](http://www.jointcommission.org/accreditation/accreditation_publicity_kit.aspx).

It includes:

- Suggestions for celebrating your accreditation;
- Guidelines for publicizing your Joint Commission accreditation;
- Frequently asked questions;
- Sample news releases and information;
- Fact sheets; and
- “Gold Seal of Approval™” artwork that can be downloaded.

Following your survey, information about your accreditation status will be posted on Quality Check® at [www.qualitycheck.org](http://www.qualitycheck.org), which is also available on the Joint Commission web page. Quality Check® allows anyone to search for health care organizations within a city or state, or by type of setting, and will highlight your Joint Commission accreditation status.



**The Joint Commission Gold Seal of Approval™**

## **Information for Resurveys**

In the three years between on-site surveys, The Joint Commission requires ongoing self-assessment and continuous improvement activities. As the accreditation process does not end when the on-site survey is completed, neither do the need for updates and changes to policies and procedures. Below are updates to specific procedures for the accreditation process.

Accredited organizations undergoing future surveys are encouraged to read this section to prepare for future changes, as well as continually study and improve their systems and operations as continuous compliance with the Joint Commission standards contributes directly to quality patient care.

## Unannounced Surveys

Since January 2006, organizations that have already completed their initial survey are surveyed on an unannounced basis. The Joint Commission implemented unannounced surveys:

- To enhance the credibility of the accreditation process by ensuring that surveyors observe organization performance under normal circumstances;
- To reduce unnecessary costs that health care organizations incur to prepare for survey;
- To address public concerns that The Joint Commission receive an accurate reflection of the quality and safety of care; and
- To help health care organizations focus on providing safe, high quality care at all times, not just when preparing for survey.

### **Organizations undergoing an unannounced survey should be aware of the following:**

- Joint Commission surveys are unannounced and occur 18 to 36 months after the previous full survey.
- On the morning of an organization's unannounced survey, the following information will be sent via email to the listed CEO and Primary Accreditation Contact and be posted by 7:30 am (local time) to your Joint Commission extranet site, "Joint Commission Connect®":
  - Letter of introduction from The Joint Commission
  - Survey agenda
  - Biography and picture of surveyor(s) assigned
- The organization will be invoiced immediately after the survey
- Accredited organizations will be able to identify up to 15 days each year in which an unannounced survey should be avoided. These 15 days should not include federal holidays but may include regional events in which it may be difficult to conduct a survey during a given period. The Joint Commission will make every effort to accommodate the organization regarding avoiding these 15 days. However, The Joint Commission reserves the right to conduct a survey during an "avoid period" if the reason(s) given to avoid a survey at that time are such that a survey can be reasonably accomplished.
- The organization is required to fulfill an Accreditation Participation Requirement (APR), which requires organizations seeking accreditation to continuously inform the public about their organization's ability to report any complaints or concerns about safety to The Joint Commission; and
- The organization won't receive communication from the surveyor prior to survey.

For more information regarding unannounced surveys, review the [Ready to Go List](#) provided in the references section of this guide, and/or refer to the **Survey Activity Guide** on the Joint Commission extranet site Joint Commission Connect®.



## Reference Checklists and Tables

### Ready to Go List

As a Hospital, you will need the following information and documents available for the surveyor to review during the Preliminary Planning Session and Surveyor Planning Session, which occurs on the first day of survey.

*Note: The 12-month reference in the following items is not applicable to initial surveys.*

- 1) Hospital license
- 2) CLIA certificates
- 3) An organization chart
- 4) Name of key contact person who can assist surveyors in planning tracer selection
- 5) A map of the organization, if available
- 6) List of all sites that are eligible for survey
- 7) List of sites where deep or moderate sedation is in use
- 8) List of sites where high-level disinfection and sterilization is in use
- 9) List of departments/units/ areas/programs/services within the organization, if applicable
- 10) List of patients that includes: name, location, age, diagnosis and length of stay, admit date, source of admission (*ED, direct admit, transfer*)
- 11) Lists of scheduled surgeries and special procedures (*e.g. cardiac catheterization, endoscopy lab, Electroconvulsive Therapy, Caesarian Sections, including location of procedure and time*)
- 12) List of unapproved abbreviations
- 13) List of all contracted services
- 14) Agreement with outside blood supplier
- 15) Organ Procurement Organization agreement
- 16) Tissue and Eye Procurement Organization agreement
- 17) Organ, tissue and eye procurement policies
- 18) Performance improvement data from the past 12 months
- 19) Documentation of performance improvement projects being conducted, including the reasons for conducting the projects and the measurable progress achieved (*this can be documentation in governing body minutes or other minutes*)
- 20) Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being conducted (*including reasons for conducting the projects*); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping
- 21) Analysis from a high risk process
- 22) Organ donation and procurement conversion rates (*Hospital*)
- 23) Environment of Care data
- 24) Environment of Care Management Plans and annual evaluations
- 25) Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey

- 26) Emergency Operations Plan (*EOP*) and annual evaluation
- 27) Hazard Vulnerability Analysis
- 28) Emergency management drill records and after action reports
- 29) Written fire response plan
- 30) Interim Life Safety Measure policy
- 31) Fire drill evaluations
- 32) Infection Control Plan:
  - a) Annual risk assessment and Annual Review of the Program
  - b) Assessment-based, prioritized goals
- 33) Infection Control surveillance data from the past 12 months
- 34) Medical Staff Bylaws and Rules and Regulations
- 35) Medical record delinquency data (*Critical Access Hospitals only*)
- 36) Medical Executive Committee meeting minutes
- 37) The organization's signed and dated agreement with the QIO; in absence of an agreement with a QIO, the organization's Utilization Review plan (*Not applicable to Critical Access Hospitals unless the operate Rehab and Psych Distinct Part Units*)
- 38) Governing Body minutes for the last 12 months
- 39) Autopsy policy
- 40) Blood transfusion policy
- 41) Complain/grievance policy
- 42) Restraint and seclusion policy
- 43) Waived testing policy and quality control plan
- 44) ORYX data (*required only for very small hospitals exempt from submitting this data through vendors*)
- 45) Available regulatory reports (*CMS, State*)
- 46) Medication management policy (*include definition of what is a complete medication order and therapeutic duplication*)
- 47) Abuse and neglect policy for inpatient sites, and ambulatory sites if applicable
- 48) Fall risk assessment and policy
- 49) Document describing how the organization is using the CDC's Core Elements of Hospital Antibiotic Stewardship Programs
- 50) Organization approved antimicrobial stewardship protocols (*e.g. policies, procedures, or order sets*)
- 51) Antimicrobial stewardship data
- 52) Antimicrobial stewardship reports documenting improvement (*Note: If the data supports that antimicrobial stewardship improvements are not necessary make sure the surveyor is informed.*)

**Please note** that this is not intended to be a comprehensive list of documentation that may be requested during the survey. Surveyors may ask, on an as needed basis, to see additional documents throughout the survey to further explore or validate observations or discussions with staff.

## Hospital Accreditation Survey Activity List

Survey Activity Name	Suggested Duration of Activity	Suggested Scheduling of Activity	Organization Participants (Refer to Survey Activity Guide for more info.)
Surveyor Arrival and Preliminary Planning	30 – 60 minutes	Day 1, upon arrival	
Opening Conference and Orientation to the Organization	30 – 60 minutes	Day 1, as early as possible	
Surveyor Planning Initial	30-60 minutes	Day 1, as early as possible	
Individual Tracer	60-120 minutes	Individual Tracer activity occurs each day throughout the survey; the number of individuals that surveyors trace varies by organization. If travel is required to perform tracer activity (e.g., to an outpatient setting), it will be planned into this time.	
Lunch	30 minutes	At a time negotiated with the organization	
Issue Resolution	30 minutes	End of each day except last; can be scheduled at other times as necessary	
Team Meeting/ Surveyor Planning	30 minutes	Mid-day and/or end of each day except first and last	
Daily Briefing	30-45 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary	
Competence Assessment	30-60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Medical Staff Credentialing & Privileging	60 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Environment of Care	60-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
Emergency Management	60-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization	
System Tracer – Data Management	60 -90 minutes	After some individual tracer activity has occurred; at a time negotiated with the organization. If this is the only system tracer taking place during survey, the topics of Infection Control and Medication Management will be covered in this discussion.	
Leadership	60 minutes	Middle or end of survey at a time negotiated with the organization	
Report Preparation	60-120 minutes	Last day of survey	
CEO Exit Briefing	15-30 minutes	Last day of survey	

<b>Survey Activity Name</b>	<b>Suggested Duration of Activity</b>	<b>Suggested Scheduling of Activity</b>	<b>Organization Participants (Refer to Survey Activity Guide for more info.)</b>
Organization Exit Conference	30-45 minutes	Last day, final activity of survey	
<b>Note: The following activities may be incorporated into the survey agenda as noted under the Suggested Scheduling of Activity column.</b>			
System Tracer – Infection Control	60 minutes	Occurs on surveys greater than three days in duration. After some individual tracer activity has occurred, at a time negotiated with the organization.	
System Tracer – Medication Management	60 minutes	Occurs on surveys greater than three days in duration. After some individual tracer activity has occurred; at a time negotiated with the organization.	
Interim Exit – w/ early departing surveyors & Org.	30 minutes	At the end of any day another program surveyor or Life Safety Code Specialist is departing from the survey in advance of the team	
<b>Life Safety Code® Survey Activity</b>			
Life Safety Code Specialist Arrival and Preliminary Planning Session	30 minutes	LSCS survey Day 1, early	
Facility Orientation/ Maintenance Document Review	60-90 minutes	At a time negotiated with the organization	
Life Safety Code® Building Assessment	2 - 5 hours per day	At a time negotiated with the organization	
Lunch	30 minutes	At a time negotiated with the organization	
Facility Maintenance / Document Review (Critical Access Hospital ONLY)	60-90 minutes	At a time negotiated with the organization	
Environment of Care & Emergency Management (Critical Access Hospital ONLY)	60-90 minutes	At a time negotiated with the organization	
Facility Tracer / Issue resolution (Critical Access Hospital ONLY)	30 minutes	At a time negotiated with the organization	
Report Preparation	60 minutes	Towards the end of last day of survey	
Interim Exit	30 minutes	Last activity on last day of survey	
<b>California Hospital-- Unique Survey Activities</b>			
CDPH – System Tracer – Medical Staff Functions/Regulatory Review	60 minutes	At a time negotiated with the organization	

<b>Survey Activity Name</b>	<b>Suggested Duration of Activity</b>	<b>Suggested Scheduling of Activity</b>	<b>Organization Participants (Refer to Survey Activity Guide for more info.)</b>
IMQ – System Tracer – Medical Staff Leadership	60 minutes	At a time negotiated with the organization	
CDPH – System Tracer – Dietetic Service and Food Service Visit	60 minutes	At a time negotiated with the organization	
CDPH – System Tracer – Pharmaceutical Services and Clinical Unit Inspection	60 minutes	At a time negotiated with the organization	

# Hospital Accreditation Readiness Checklist

## Preparing for Accreditation

- \_\_\_\_\_ Obtain the *Comprehensive Accreditation Manual for Hospitals (CAMH)*
  - Telephone Business Development at 630-792-5291
  - Email your request to [hospital@jointcommission.org](mailto:hospital@jointcommission.org)
  - Request a free trial edition of the hospital standards in the Accreditation > Hospital section of [www.jointcommission.org](http://www.jointcommission.org)
  
- \_\_\_\_\_ Organize an interdisciplinary accreditation readiness team. Conduct a self-assessment to see where improvements need to be made.
  
- \_\_\_\_\_ Distribute the *CAMH* to organization staff with responsibility for ensuring standards compliance. Review the standards and elements of performance. If you have questions on how standards are applied, they can be submitted through the “Contact Us” link at [https://www.jointcommission.org/standards\\_information/jcfaq.aspx](https://www.jointcommission.org/standards_information/jcfaq.aspx).
  
- \_\_\_\_\_ Access current standards information and expectations on the Joint Commission website under “What’s New” at [www.jointcommission.org](http://www.jointcommission.org).
  
- \_\_\_\_\_ Use the expertise of The Joint Commission’s affiliate to help prepare for accreditation. Joint Commission Resources (JCR) offers seminars, custom education, and numerous publications. Go to [www.jcrinc.com](http://www.jcrinc.com) for up to date information on available resources.
  
- \_\_\_\_\_ Implement standards compliance into daily operations prior to the date of your on-site survey. Note specifically the following requirements which can be found in the current edition of the *CAMH*:
  - \_\_\_\_\_ Demonstrate compliance with the National Patient Safety Goals.
  
  - \_\_\_\_\_ Conduct a proactive risk analysis of at least one high-risk process as per standard LD.04.04.05, EP 10
  
  - \_\_\_\_\_ Conduct a Hazard Vulnerability Analysis (HVA) as per standard EM.01.01.01, EM.03.01.01 to inform development of an Emergency Operations Plan
  
  - \_\_\_\_\_ Demonstrate compliance with the Staffing Effectiveness requirements PI.02.01.01, EPs 12-14
  
  - \_\_\_\_\_ Establishes and conducts annual evaluations of Environment of Care management plans EC.01.01.01, EC.04.01.01, EP 15
  
  - \_\_\_\_\_ Demonstrate compliance with the Public Information policy APR.09.01.01

## Applying for Accreditation

- \_\_\_\_\_ Request an Application for Accreditation by calling 630-792-5291.
- \_\_\_\_\_ Receive a password for accessing the application on your secure Joint Commission extranet site on Joint Commission Connect™.
- \_\_\_\_\_ Submit the Application for Accreditation electronically.
- \_\_\_\_\_ Mail the initial application deposit to The Joint Commission at PO Box 92775, Chicago, IL 60675, or pay by credit card by calling 630-792-5115.
- \_\_\_\_\_ Obtain the name of your assigned account executive who will help you throughout the accreditation process.
- \_\_\_\_\_ Review information on your Joint Commission extranet site including the Survey Activity Guide, which details on-site activities.
- \_\_\_\_\_ Review issues of *Perspectives*, which is the Joint Commission's official newsletter accessible on your Joint Commission extranet site under the Continuous Compliance Tools section. Any revisions or additions to policies, standards, survey process, etc. are published in this official newsletter, often up to a year in advance of taking effect.

## Customized On-Site Survey

- \_\_\_\_\_ Receive a customized on-site survey using the Tracer Methodology. After the survey, you will receive your final report, clearly outlining your organization's performance. If you have any Requirements for Improvement, you'll need to present Evidence of Standards Compliance (ESC), within 60 days, to demonstrate the corrective measures that you have implemented. Once the ESC is accepted, your organization is accredited and your status is posted on the Joint Commission web site at [www.qualitycheck.org](http://www.qualitycheck.org).

## Publicizing your accreditation

- \_\_\_\_\_ A publicity kit is available on The Joint Commission Connect website that will show you many ways to publicize your accreditation status to the public you serve.





